STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366097	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Nursing & Rehab C	723 South Shoop Avenue Wauseon, OH 43567

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of policy, the facility failed to notify the physician of weight deviations in accordance with physician orders. This affected one (#62) of two residents reviewed for weight. The facility census was 65.Findings include:Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included renal failure, type II diabetes mellitus, hypertension, hypertensive heart and chronic kidney disease with heart failure with stage five chronic kidney disease, disorder of the kidney and ureter, and peripheral vascular angioplasty with implants and grafts.Review of the Minimum Data Set (MDS) assessment, dated 03/31/26, revealed Resident #2 was assessed with no cognitive impairment and received dialysis treatments. Review of the care plan dated 02/27/26 revealed Resident #2 was to be weighed at the same time of day and recorded as ordered. Review of the clinical record revealed a physician order, dated 03/03/26, to weigh Resident #2 daily for three days with no end date. Further review revealed to notify the physician of weight gains of three (3) pounds (lbs.) in twenty-four (24) hours or five (5) lbs. in one week.Review of the weight record summary from 02/26/26 to 04/13/26 revealed Resident #2 had weight fluctuations of three or more pounds of weight gain in 24 hours on the following days; from 02/26/26 (183.0 lbs.) to 02/27/26 (186.2 lbs.), the resident gained 3.2 lbs.; from 03/01/26 (186.2 lbs.) to 03/02/26 (191.7 lbs.), the resident gained 5.5 lbs., from 03/15/26 (169.9 lbs.) to 03/16/26 (175.5 lbs.), the resident gained 5.6 lbs.; from 03/19/26 (168.0 lbs.) to 03/20/26 (176.2 lbs.), the resident gained 8.2 lbs.; from 04/02/26 (164.0 lbs.) to 04/03/26 (168.3 lbs.), the resident gained 4.3 lbs., from 04/05/26 (165.3 lbs.) to 04/06/26 (176.4 lbs.), the resident gained 11.1 lbs.; from 04/08/26 (164.1 lbs.) to 04/09/26 (171.6 lbs.), the resident gained 7.5 lbs.; and from 04/09/26 (171.6 lbs.) to 04/10/26 (175.4 lbs.), the resident gained 3.8 lbs.Review of the progress notes dated 02/26/26 to 04/13/26 for Resident #2 revealed no evidence of documentation verifying the physician was notified of Resident #2's weight deviations of more than 3 lbs. of weight gain in 24 hours on the above dates per physician's orders. Interview on 04/14/26 12:49 P.M. with Registered Nurse (RN) #501 verified she was unable to locate any documentation in Resident #2's medical record where the physician was notified of the resident's weight gain in 24 hours as listed above.Interview on 04/14/26 1:05 P.M. with Assistant Director of Nursing (ADON) #359 verified Resident #2 did not have any documentation of daily or weekly weight gains being communicated to the physician by the nursing staff for the above dates in February, March, and April 2026.Review of the undated policy titled, Change of Status Notification, revealed the facility will notify the attending physician and the resident's advocate of any significant change in the resident's medical condition immediately. The Facility will use the following means to notify the residents advocate or the physician including telephone notification within the specified time, written notification within the specified time, interoffice memo within the specified time, e-mail with the specified time, or secured messaging service within the specified time.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and review of a facility policy, the facility failed to adequately monitor bowel movements and implement bowel protocol as needed. This affected one (#6) of one residents reviewed for bowel and bladder. The facility census was 65.Findings include:Review of the medical record revealed Resident #6 was admitted on [DATE]. Diagnoses included spinal stenosis, paroxysmal atrial fibrillation, hypertensive chronic kidney disease, chronic kidney disease stage III, hyperlipidemia, hypothyroidism, fibromyalgia, and dysphagia.Review of the Minimum Data Set (MDS) assessment, dated 02/25/26, revealed Resident #6 was moderately cognitively impaired and required partial/moderate assistance with toileting. The resident was occasionally incontinent of bladder and always continent of bowel.Review of the most recent care plan verified Resident #6 had a focus areas for constipation due to decreased mobility, diminished appetite, and use/side effects of medication. Interventions were numerous and included to record bowel movement pattern each day (describe amount, color, and consistency) and follow facility bowel protocol for bowel management. Review of bowel tracking for the last 30 days revealed Resident #6 did not have a documented bowel movement beginning 03/31/26 to 04/06/26. Further review of Resident #6's medical record revealed no evidence of the facility addressing the lack of bowel movements over this time frame.Interview on 04/16/26 at 1:01 P.M. with the Director of Nursing (DON) verified the lack of documentation for the facility addressing Resident #6's bowel movements or if the facility implemented a bowel protocol as needed. The DON reported Resident #6, at times, would take herself to the bathroom. The DON reported on 04/07/26 at the clinical meeting, Resident #6's lack of documented bowel movements in six days were discussed. The facility nurse spoke to the resident and determined she recently had a bowel movement. The DON verified the facility did not document or monitor Resident #6's bowel movements until there had been no documented bowel movement for six days. Review of the facility undated bowel protocol policy revealed bowel movements will be documented at the end of each shift by the aide responsible for the resident's care. The bowel protocol includes the following standing order medications being provided each shift until the resident has a bowel movement: prune juice, milk of magnesia, Dulcolax suppositories, and Fleets enemas. Nurses will monitor bowel movements each day. The third shift nurse will run a report that will indicated which residents have had no bowel movement in the past two days. When this is noted the nurse will review the medication administration record to determine if bowel medications are needed per the protocol and will contact the physician to obtains orders as appropriate.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to obtain resident weights as ordered to determine gains and losses for weight monitoring. This affected one (#62) of two residents reviewed for weight. The facility census was 65.Findings include:Review of the medical record revealed Resident #62 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, chronic obstructive pulmonary disease (COPD), and hypertension.Review of the MDS assessment dated [DATE] for Resident #62 revealed no the resident was assessed as cognitively intact. Review of Resident #62's medical record revealed a physician order dated 10/28/24 directing staff to monitor, record, and report to the physician significant weight loss of three (3) pounds (lbs.) in one week, greater than 5 percent (%) in one month, greater than 7.5% in 3 months, or greater than 10% in six (6) months.Review of Resident #62's medical record revealed a physician order dated 10/15/25 for staff to weigh the resident weekly and to notify the physician of any 3 lbs. or greater weight gain in a day or 5 lbs. in a week with the resident to be weighed every day shift every Saturday for weight monitoring.Review of the weight-record summary for Resident #62 reveled the resident had no documented weights between 09/14/25 through 09/29/25 and 10/04/25 through 10/17/25 to determine if the resident lost more than 3 lbs. in one week. Further review revealed Resident #62 was not weighed weekly and/or daily to determine if 3 lbs. was lost or 5 lbs. were gained in one week or 3 lbs. were gained in one day from 10/19/25 through 11/05/25, 11/07/25 through 12/05/25, 01/01/26 through 01/06/26, 01/25/26 through 01/31/26, 02/02/26 through 02/20/26, 02/22/26 through 02/27/26, 03/03/26 through 03/06/26, 03/08/26 through 03/13/26, 03/15/26 through 03/20/26, and 03/22/26 through 03/31/26.Review of Resident #62's progress notes for September 2025 through March 2026 revealed no evidence of the resident being weighed for any of the missing time frames as noted above. Interview on 04/16/26 at 8:42 A.M. with Assistant Director of Nursing (ADON) #450 verified Resident #62 did not have any documentation of her daily or weekly weights being obtained to determine if the resident had gains or losses per the physician orders.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure supplemental oxygen tubing was properly labeled and dated. This affected one (#40) of two residents reviewed for respiratory care. The facility census was 65.Findings include: Review of the medical record for Resident #40 revealed an admission date of 03/04/14 with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, hypertensive heart disease with heart failure, and congestive heart failure (CHF). Review of the Minimum Data Set (MDS) assessment, dated 03/24/26, revealed Resident #40's cognition was moderately impaired. Review of physician orders for Resident #40 revealed an order dated 01/07/26 for oxygen administration via nasal cannula at three liters per minute and an order to change and date the oxygen tubing weekly on Monday during night shift for infection prevention.Observation on 04/13/26 at 2:05 P.M. revealed Resident #40 was seated in her wheelchair with supplemental oxygen in use via nasal cannula connected to an oxygen concentrator set at three liters per minute. The oxygen tubing was not dated.Interview on 04/13/26 at 2:07 P.M. with Unit Manager #467 verified Resident #40 was receiving oxygen at three liters per minute and acknowledged the tubing was not dated.Review of the facility policy titled, Oxygen Administration, dated 09/19/23, revealed all disposable items will be changed over weekly on Mondays and will be dated on the day they are changed. This includes oxygen tubing, aerosol tubing, aerosol chambers, masks, oxygen water canisters, trach tubing and other supplies used to provide oxygen or respiratory treatment.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to establish adequate monitoring of medication side effects for anticoagulant and antianxiety medications. This affected one (#3) of five residents reviewed for unnecessary medications. The facility census was 65. Findings include:Review of the medical record revealed Resident #3 was admitted on [DATE]. Diagnoses included autistic disorder, Asperger's syndrome, chronic kidney disease stage four, heart failure, and diabetes mellitus type two.Review of the Minimum Data Set (MDS) assessment, dated 02/07/26, revealed Resident #3 was cognitively intact. Review of the most recent care plan revealed Resident #3 was care planned for use of antianxiety medications and interventions included to monitor, document, and report any adverse reactions to antianxiety therapy. Review of the physician order, dated 02/15/23, revealed Resident #3 was prescribed Xarelto (an anticoagulant) 20 milligrams (mg) by mouth one time a day for atrial fibrillation. Review of the physician order, dated 03/19/26, revealed Resident #3 was prescribed buspirone (antianxiety) 10 mg with instructions to give one tablet by mouth two times a day for anxiety.Review of Resident #3's medical record revealed no evidence of facility staff monitoring for side effects of Xarelto or buspirone. Interview on 04/14/26 at approximately 12:30 P.M. with the Director of Nursing (DON) verified Resident #3 did not have documentation of side effects being monitored for Xarelto or buspirone. Review of an undated policy titled, Behavior Management Program, revealed behavior documentation was initiated in the electronic medical record for all psychoactive medications that are in use to include monitoring for effectiveness, side effects, and adverse effects of the medication. Review of an undated policy titled, Anticoagulant Therapy, revealed all residents receiving anticoagulant therapy will be monitored daily for any signs or symptoms of internal bleeding such as hematuria or excessive bruising or any change in mental status.